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ABSTRACT

This document presents guidelines for school staff to use in responding to an adolescent suicide. It gives statistics on teenage suicides and suicide attempts and examines characteristics of high-risk adolescents. Behavior patterns associated with adolescent suicide are described, paying close attention to the patterns of depression, substance abuse, and homosexuality. Risk factors associated with adolescent suicide, personality traits of high-risk adolescents, and the contagion effect of adolescent suicide are discussed. A chapter on the response to suicide focuses on intervention, prevention, and reaction. The formation of a school crisis team is explained and suggested procedures for the team to use in dealing with suicide-related referrals are listed. A reaction outline presents a compilation of several school districts' responses to student suicides. It is noted that the model presented can be adjusted to address suicide attempts or other emotionally catastrophic events. Eleven recommendations by the Sudden Adolescent Death Committee concerning an adolescent suicide are listed. The final section discusses an early detection and treatment program for adolescent suicide prevention. An epilogue contains a statement of suicide addressed to the Grosse Pointe, Michigan community. Relevant materials on drug abuse, copy cat suicides, a lethality assessment, and a resource directory are appended. (NB)

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October, 1986

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## FOREWORD

The Wayne County Intermediate School District is proud to publish **The Tree of Life: A Response to Teen Suicide**, the product of a Grosse Pointe Public School System program to address the critical issue of suicide among today's youth.

We gratefully acknowledge the dedication and hard work of the Grosse Pointe Sudden Adolescent Death Committee, the contribution of time, effort and expertise of author Dr. Claire Y. Hunt, and the willingness of the Grosse Pointe System to provide this valuable resource to others who share responsibility for the children of our schools.

# THE TREE OF LIFE

Once there was a man who was given a beautiful fruit tree.

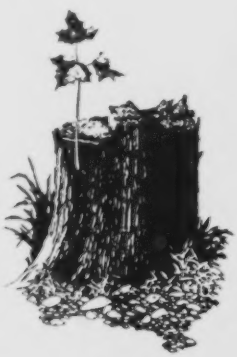
He loved the colors of its leaves, the sweetness of its fruit.

Then, one day the leaves began to wither and turn brown. Suddenly, the branches were bare.

The man was grief stricken. "It is dead," he told himself. "Somehow I have killed it." With an aching heart, he brought an axe to chop it down.

"Wait," said his neighbor, "it is not dead. In Spring it will bloom again." And gently, he persuaded the man to put aside the axe.

Before long, it was as the neighbor had predicted. Leaves and blossoms reappeared and once more the tree bore fruit. And the man came to understand that Winter is always followed by Spring.



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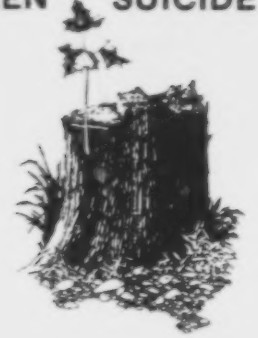
Special appreciation is extended to Dorothy Combs and Doris Pfaehler for their efforts.

# TEEN SUICIDE



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# Introduction

I

Alarmed by the increasing number of completed suicides and suicide attempts, a committee was formed by the direction of The Grosse Pointe Public School System to address this issue. Dr. John Whritner, Superintendent, G.P.P.S.S., requested that the committee be selected which would represent public, parochial and private schools; the Ministerial Association; Catholic churches; service organizations; and health agencies. A charge was made to the committee that a model be generated which could be utilized by different organizations to address teen suicide. Professionals, parents and students met from December, 1985 through April, 1986. Subcommittees held many additional sessions.

Many hours were devoted to this project in personal research and in small committee meetings. An impressive amount of background information was considered by the committee. This effort is a synopsis of more bulky reports which were reviewed at length, as well as two subsequent publications distributed by The Grosse Pointe Public School System.

Operating agencies are welcome to use parts or all of the report as appropriate. The report should be regarded as a **guideline** to assist in helping students, staff and parents.

The contents may be adapted by a school to accommodate special circumstances and may be of assistance to administrators, and school staffs to address catastrophic events other than suicide.

## Committee Members

A special debt of gratitude is owed to the following community members for their assistance in the publication of Sudden Adolescent Death, the first of three booklets distributed by The Grosse Pointe Public School System.

| | |
|---|---|
| Monsignor Canfield | Pastor, St. Paul's Catholic Church |
| Lydia Demeulemeester | School Social Worker, Grosse Pointe Public School System |
| Nicole DuPont | South High School student representative |
| Gail Erickson | Substance Abuse Co-ordinator, Grosse Pointe Public School System |
| Kendra Harding | Community member Survivor of suicide |
| Sr. Arlene Hepp | Director, Religious Education, St. Paul's Parish |
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| | |
|---|---|
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| Cathy Obeid | North High student representative |

| | |
|---|---|
| Frank Parcells, M.D. | Former President of the Grosse Pointe Board of Education<br>Consulting Psychiatrist |
| Sr. Jean Philip Lucid | Ministry to the Bereaved, St.Paul's Parish |
| Becky Reedus | Executive Director, Family Life Education Council |
| Betsy Schoof | SAC 2<br>Substance Abuse Council |
| Joseph Spagnoli | Deputy Superintendent, Grosse Pointe Public School System |
| Thomas Teetaert | Assistant Principal North High School Grosse Pointe Public School System |

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## WE CAN MAKE A DIFFERENCE

Dr. Jack Durrell from the National Institute of Drug Abuse, Department of HHS, made an eloquent plea on behalf of young people at a recent conference by a Presidential Task Force on Youth Suicide held in Berkley, California. In light of the task force assignment, he urged that life must be lived forwards but must be examined backwards.

Any study of how to prevent young people killing themselves is a gathering in a celebration of life and how to perceive it against the sense of futility and sadness which haunts some children.

People working with teens were urged to **talk more to them, provide open support, confront issues and to regard suicide as a human loss.**

The statistics that are rattled off so glibly from time to time are a sad account of broken hearts and broken spirits. The suicide rate is a generation of young people telling us that they need guidance, support and love. It is essential that young people see strong examples of good role models. The youth of America need friends. They need you and me.

There is something that adults who work with young people can do:

**Listen and tune in**
**Prod for the hidden agenda**
**Counsel kids to get help**
**Say so if a teen's actions worry us**
**Reassure adolescents**
**Acquaint ourselves with problem signs**
**Help young people to make friends and to know how to be a friend**
**Help young people understand that they are a part of the responsibility of the problem and must accept responsibility for their own actions**
**Encourage young people to help and boost each other**

# Background Information

II

This year about two million young people between the ages of 15 and 19 will attempt suicide. About 5000 will kill themselves. Some authorities estimate the real figure to be four times higher as many are masked as accidents and homicides. At least one in ten persons under 19 years of age attempts suicide sometime during adolescence.

At high school age, 30% of the suicides occur among school dropouts. At college age, more college than non-college young people take their own lives.

Girls account for 90% of the suicide attempts; boys for 70% of the actual suicides. Whites have a considerably higher suicide rate than blacks.

Girls generally select sleeping pills or slitting their wrists as their means of suicide. Boys tend to choose hanging or shooting.

According to a recent study, the majority of young people who kill themselves have a history of alcohol and other drug abuse. (Appendix A) Many overdoses are suicide attempts that are mislabeled by a lack of information or efforts to shield the survivors.

Dr. Alan Berman, past president of the American Society of Suicidology, reports that about half of the adolescents who attempt suicide show signs of depression, such as changes in appetite, weight, sleeping patterns, and attitudes toward school or friends. He states teenagers who attempt suicide are often high achievers "desperately trying to meet perceived expectations."

Dr. Berman also notes that there is an increased risk of suicide in families where biochemical depression occurs in other family members, or where established role models shape depressed behavior.

Suicidal behavior often is undetected in the adolescent because of the difficulty in differentiating between abnormal and normal behavior.

Adolescence is characterized by wild mood changes and unusual stresses of emerging adulthood.

For every suicide that is completed, it is estimated that 120 attempts can be counted.

This alarming rate demands an explanation and action on the part of those who are treating or working with young people. For many years, suicide has been stigmatic and because of that, the subject was kept in the closet and, therefore, secret. Dr. Shervert Fraser, National Department of Mental Health, stresses that the issues precipitating suicide are complex and interrelated.

No common pathways have been identified that will predict which young people will actually attempt suicide. A presidential task force assigned to address teen suicide had hoped to produce a common profile for prediction and treatment purposes. While task force members have so far been unsuccessful, they did find that young people who do commit suicide tend to have greater involvement with some of the following characteristics:

**Impulsive/aggressive families**
**Unwanted pregnancies**
**Minority group**
**Substance abuse**
**Sexual abuse or neglect**

There is a more predictive effect if some of the aforementioned characteristics are coupled with **bleak life opportunities, unusual stress and high pressure to succeed or compete.**

It is incumbent upon educators and community agencies to seek ways to innoculate against the stress that might precipitate a young person to attempt or complete suicide.

## PERSPECTIVES ON YOUTH SUICIDE

### Psychological Autopsies

Some members of the presidential task force on teen suicide attempted to do what they described as psychological autopsies. The team members investigated coronors' reports, then interviewed family members, friends and teachers of the deceased in order to try to cull out precipitating factors.

Dr. Robert Litman, Chief Psychiatrist for the Institute for Studies of Destructive Behaviors and Suicide Prevention, relates the following:

About 50% of students attempting or committing suicide have had contact with school social workers or counselors. Yet, almost all the therapists who had been working with the teens in question registered surprise that suicide had occurred.

Many teens committing suicide are school drop-outs.

Of a hundred teens who think about killing themselves, one will.

There seems to be a multiplicity of factors for committing suicide.

Many suicide attempts go unreported. Frequently, not even a teen's parents will know about it.

Teens may go in and out of the suicide zone. Things are going o.k. one day--they're out. Next day things are not o.k.--they're in.

Younger people react differently to the idea of self-destruction than older people. Normally, a suicidal person is asked by a therapist,

"Did you try?"
Are you thinking about it now?"
"Are you depressed?"
"Are you upset?"

Questions such as these stated may not be enough. A teen may say no and mean it because an adult is talking to him/her and cares, but commit suicide if left alone, or a teen may be temporarily out of the suicide zone.

**The following suggestions may, therefore, help:**

A therapeutic team approach is better than individual approach.

Family therapy fights denial.

History of suicides in family is a high risk factor and needs to be addressed.

School problems should be taken seriously.

Good role modeling is necessary.

## COMMON ELEMENTS

Some of the common elements which appear to describe a teen attempting suicide are:

**A sense of aloneness**
**Attempts to relieve alienation**
Example: turning to drugs
**Do not ask directly for help**
(but ask why they have not been heard)

Going to a therapist or mental health counselor does not automatically insure that the teen will receive the needed assistance. Some therapists balk and the encounter is counterproductive if:

1. **The kid is a smart aleck**
2. **Is using drugs**
3. **Is homosexual**

One of the roadblocks to recognizing that someone is contemplating suicide is the enormous responsibility that is subsequently put upon that person as a result of the realization. Adults who work with young people have to remember that they are not omnipotent. It is important in the helping professions to work as a team; to work together and to respond with kindness.

School personnel need special caution that they should not attempt to bear the burden alone but must share information with a team.

## SPIRITUAL ISSUES AND YOUTH SUICIDE PREVENTION

William Wendt, Executive Director of the St. Francis Center in Washington, D.C., suggests some reasons why suicide may be more attractive to younger people. Among these he lists

**loss of innocence**
**a loss of benign adult images or models**
**loss of idea of romance**

In order to look at the concept of death and dying, it is important to examine life and living.

Preventive programs which have a chance of succeeding must have the support of the administration.

The whole issue of death and dying, or life and living, should be considered as a high school course. There are many mini-deaths that young people experience as they go through life. Among these are breakups and separation (graduation). Students need to be taught coping skills, how to deal with failure and how to deal with life. In one successful program in Washington, D.C., the course plan includes a trip to the funeral home and cemetery to get a view of the enormity and finality of death. By studying death, life becomes more precious. A course on death and dying should in reality be a celebration of life.

## ENVIRONMENTAL RISK

Dr. Pamela Cantor, Past President of the American Association of Suicidology, listed some predisposing factors in the environment which may contribute to the increase of suicide and attempts. These included

1. **environmental**
2. **high competition and pressure**
3. **social isolation and alienation**
4. **T.V. violence**
5. **lack of socially acceptable ways of handling anger**
6. **lack of religion**
7. **growing up too quickly**
8. **use of alcohol and drugs**
9. **divorce**
10. **stress**
11. **lack of extended families**

The suicide rate will probably continue to decline as the numbers of teens within that population similarly drops.

Of particular high risk is the practice of tasting of privileges historically reserved for adults. This would include so-called sexual freedom in which children are participating in sexual acts without emotional maturity.

Another high risk factor is the changing family in the United States. There are increasing single parent families which necessitates that a teen will necessarily be alone at least part of the day.

Where family bonds are strong, suicide figures are down.

Guns are more involved in completed suicides since the intervention methods for poisoning and/or overdoses is so sophisticated that many of these are saved from death. It is now commonly accepted that if the more lethal means of ending life are removed and a young person is bent on suicide, he/she will go to a less lethal means.

If a young person is incarcerated for any reason, the first 24 hours are the most dangerous for suicide completion.

## Information About Suicide

III

While we cannot generate any suicidal profile with accuracy, there are three dimensions which in any combination vastly increase likelihood of suicide. Certain behavior patterns, personality traits and risk factors may produce catastrophic events when particular psychological stresses occur in a young person's life.

**BEHAVIOR PATTERNS**

Any change in a person's behavior may be indicative of problems that he/she is facing, and should be explored for the possibility of suicide intent. The following are some of the most common signs:

1. Eating Problems - either eating too much or too little.

2. Sleeping Problems - sleeping too much or too little, waking up too early.

3. Social Withdrawal.
   a. Less participation in classes.
   b. Dropping out of extracurricular activities.
   c. Less "hanging out".
   d. Quitting part-time job.

4. Decrease in Self-Care.
   a. Appearance looks messier/school work is less carefully done.
   b. Increased tardiness and/or absence from school/work.
   c. Falling grades/work performance.

Behavior Patterns
(continued)

5. Emotional Behavior.
   a. Crying easily or for no apparent reason.
   b. Rowdy behavior or physical fighting.
   c. Looking only at the negative/hopeless side of life or a focus on death.
   d. Verbal expressions such as "I can't take it anymore", "I just want to die", "You won't have to worry about me anymore", etc.
   e. Greater irritability and intolerance.
   f. Frequent daydreaming.
   g. Talking about joining someone who is already dead.

Behavior Patterns (continued)

6. Getting Things in Order.
   a) Accomplishing tasks previously put off (e.g. cleaning up room, getting haircut, catching up on homework).
   b) Giving away things - usually valued objects.
   c) Making plans to donate body.
   d) Paying debts/getting finances in order.
   e) Visiting old friends/relatives - apologizing for old (often forgotten) arguments.
   f) Giving a note to a friend to give a family member "in a couple of days" or "if something happens to me".
   g) Circling or writing down songs or poems that talk about suicide, death, or afterlife.
   h) Arranging to give away pets.

7. Increased Use/Abuse of Drugs Including Alcohol.

8. Buying a Gun, Razor, Rope, Pills, etc.

9. Sudden Dramatic Improvement After a Period of Depression or Serious Problem.

Behavior Patterns (continued)

10. Recent Loss.
    a) Death (natural, accidental or suicidal) of a family member or friend, or anniversary of death.
    b) Failure at school or job.
    c) Health problems and complaints (e.g. frequent headaches, stomach aches, visits to school nurse).
    d) Breaking up of a relationship with boy or girlfriend.
    e) Violent, unresolved or protracted arguments with parent/other family members or friends.
    f) Divorce of parents.

11. Previous Suicide Attempts/Family History of Suicide.

12. Loss or lack of friends.

13. Self-destructive acts
    a. self-mutilation
    b. scratching
    c. accident prone

## ADOLESCENT AT RISK

Three behavior patterns which impact dramatically on teen suicide are given considerable weight. Because of their complex nature, **depression, substance abuse** and **homosexuality** are discussed at some length.

### DEPRESSION

A high percent of depressed adolescents say they have seriously thought about hurting themselves, yet less than one in three seek treatment for their depression. It needs to be emphasized that no single cause seems to be related to clinical depression, it is a multidimensional, multicausal problem with family dynamics, family history, and genetics playing major roles.

For whatever reasons, depressed adolescents feel as though they cannot communicate with their parents or significant others. They feel isolated and alone when they desperately need to seek attachments and intimacy. However, they frequently lack the necessary social skills to develop the types of relationships they need.

Further, it has been speculated that depressed adolescents tend to have a negative interpretation of events and themselves, perceiving themselves as failures. They are filled with self-reproach and self-hatred, and have a negative view of the future.

When discussing depression, it is important to distinguish it from the normal mood swings experienced by teens. What distinguishes depression from the normal mood variation is the **duration** and **intensity** of symptoms. If the following symptoms last for at least two weeks or if there is impairment in normal functioning, a depressive disorder might be present. The following list contains symptoms of depression and the starred items are masked symptoms of teenage depression.

## SYMPTOMS OF DEPRESSION IN YOUTH

*Feelings of emptiness in life, loss of interest in usual activities

*Risk-taking behavior (driving fast, recklessly)

*Rebellious refusal to work in class or cooperate in general

Sadness (in children under six years of age, may be inferred from a persistently sad facial expression)

Anger and rage--typically expressed by verbal sarcasm and attack (angry outbursts)

Inability to concentrate or make decisions

Sensitivity with inclination to overreact to criticism

Fluctuations between indifference and apathy on one hand, and talkativeness on the other

Feelings of insufficiency to satisfy ideals

Poor self-esteem (self-criticism and blame, sense of personal failure)

Feelings of helplessness and decreased peer support

Symptoms of Depression (continued)

Withdrawing from friends, excessive television watching

Intense ambivalence between dependence and independence

Restlessness and agitation (inability to relax)

Mood swings--the quiet youngster becoming hyperactive, the outgoing youngster becoming withdrawn

Pessimism about the future

Death wishes; suicide ideas, plans and attempts

Sleep disturbance (decreased or increased)

Increased or decreased appetite

*Weight gain or loss (anorexia)

*Somatic problems (e.g., headache, stomachaches)

Preoccupation with death

Studies have shown that depressed teenagers suffer significant sleep disorders. These sleep disturbances like excessive sleeping, early morning awakenings, or problems with falling asleep at night may go on for weeks and are different from the inability to fall asleep because of high anxiety or anticipating a scary event.

Appetite is usually decreased in depressed teenage women and can develop into the severe disorders of anorexia or bulimia.

As impairment in job performance happens in adults, impairment in the teenager is similar and significant. Depressed teenagers find previously enjoyable activities as boring. Lowered grades in school and withdrawal from previously enjoyable activities are significant events that might be related to the teenager's depression.

Further, masked depressions are disguised with behaviors puzzling to those around the youth. It often manifests itself in disobedient behavior in school and at home. This masking or change of behavior is misunderstood by others and viewed as just a phase, or a deviancy rather than an indication and warning that depression actually exists. Intervention is needed--the class clown on the outside may be hurting on the inside, and the verbally abusive student may be "biting his tongue" elsewhere. Those teenagers need help!

Personal drug/alcohol use may be present in depressed youth, but usually it is a symptom and not the cause of depression. Problems existed before drug use began and substance abuse may be a form of self-medication to alleviate depression.

## TIMES OF DANGER AND RISK FOR DEPRESSION

During rites of passage (graduation from school, completion of parents' divorce, loss of a parent's daily presence, or leaving home to go to college).

Anniversaries of unhappy events (parent death, severe losses, etc.).

Holidays, particularly family holidays if family is split up.

Vacation times, especially if young person is isolated.

Change of seasons (some depression surfaces in winter, for instance).

Depressed teenagers may withdraw into fantasy and develop romantic ideas of death. This romantic response to death will mask its cold reality and absolute finality.

Symptoms of depression in youth are very similar to symptoms of suicidal behavior. However, not all depressed youth commit suicide, nor are all suicide attempts a reaction to depression. Sometimes the impulsiveness of youth, along with youth's limitations in life's experiences, finds its expression in suicidal behavior.

**WORTH NOTING**:

It is important to remember that when depression seems to disappear and is replaced by a sense of calm--especially with no change in circumstances--the depressed person is more at risk for suicide. Until that time, he/she may not have had the "energy" to carry out suicide plans. Keep the following facts in mind regarding depression in youth:

The problem student who seems to remain in trouble (truancy, sexual promiscuity, runaway) may be suffering from a masked depression, particularly if substance abuse is present. What losses did the youth experience in his/her lifetime?

Anyone with signs and symptoms of depression should be seen by a physician or a mental health professional. A doctor should be able to recognize depression and prescribe proper treatment--either through psychotherapy or medications, or a combination of those.

Depression is the "common cold" of mental illnesses and with proper treatment the success rate of overcoming it is very high. It is usually responsive to proper treatment. By being alert to depression, some tragedies can be prevented.

## Hopelessness

Hopelessness generally can be divided into three categories:

Global--"Everything has gone wrong"

Stable--"Nothing to look forward to"
"I can never be happy"

Internalizing--"Others will be better off without me"

No study supported one method of treatment to be superior over another, i.e. individual, family or group.

3.

## YOUTH AT HIGH RISK: DEPRESSION

**Teens most susceptible to depression**

Recent, major loss, like a break-up with a girlfriend or boyfriend, failure in a class, or change in body part/function

Loners

Those who lack social skills

Over-achievers

Learning-disabled and under-achievers

Those under pressure

New students

Adopted children with inadequate family bonding; blended families step-children) with inadequate family bonding

**It is Important to Note that These Characteristics, When Combined With One or More of the Following, Increase High Risk for Depression:**

Poor parent/child relationships

Absent parents

Divorced or divorcing parents

Internal family conflict, either between parents or siblings
Conflict in blended families

Financial problems, breadwinner in family unemployed

Cultural changes

Member of minority

Personal pathology

- obsessions
- fantasies
- unrealistic fears
- little impulse control

Family pathology

- one or both alcoholic parents
- depressed parents
- abusive parents
- mentally ill parent or parents
- suicidal parent

## ADOLESCENTS AT RISK: SUBSTANCE ABUSE

There are no guarantees, no "sure-fire" ways to keep a youth off drugs/alcohol, but many agree that the family is the child's best defense against drugs. The reasons teenagers do drugs/alcohol are many and cannot be described simply. Certainly an obvious one is curiosity. We do know that many adolescents who commit or attempt suicide have been involved with substance abuse. Many times they may have taken alcohol or drugs to muster up the courage to kill themselves. Generally, it has been found that adolescents who commit suicide have taken some drugs during the 24 hours preceding the suicide.

It has been well documented that the leading cause of death for 15 to 24-year olds is automobile accidents and that 70 percent of those fatal auto accidents are drug/alcohol related. Considering that 74 percent of all high school students drink, there is cause for alarm. It is difficult, if not impossible, to determine exactly how many suicide attempts are drug/alcohol related, as complete investigations are not always performed to determine the presence of drugs/alcohol. As a result, the figures that are reported are believed to be conservative and one must be skeptical of their accuracy.

Drug/alcohol users are definitely at risk for suicide for several reasons. While users, when not experiencing a high, may appear to be well-adjusted or together nonsuicidal persons, they become suicidal during a high if for no other reason than that the drug will remove normal inhibitions and impair judgment.

**How Do You Tell if a Youth is Using Drugs/ Alcohol?**

Clues may not always be obvious or conclusive. However, the presence of any of the following characteristics should be considered enough to warrant further investigation. These characteristics are common in most substance abusers.

1. Appears to be changing, becoming more irritable, secretive, unpredictable, hostile, depressed, uncooperative, apathetic, withdrawn, sullen, easily provoked, and over-sensitive.

2. Appears less responsible: tardy for school, forgetful, not completing homework, chronically absent or dropping out of school, lying, and stealing.

3. Changes friends, appearance, interests; less interested in school, sports, or activities; more interested in rock concerts and music.

4. Difficult to communicate with: refuses to talk about friends, drugs; defends friends, feels hassled, defends rights of youth; points out bad habits of parents/ adults.

5. Shows physical and/or mental deterioration. The physical/mental effects of drugs/alcohol are many and may vary from drug to drug. Users may exhibit a few or many of the symptoms as individuals vary in response to substances.

Two popular drugs among youth are alcohol and marijuana. Symptoms of their use are included. Since cocaine use is on the increase, it is also included.

**a. Alcohol Use**

Changes in habits or activities, absent from school for unaccountable reasons.

Slipping grades and missed assignments.

Change in friends.

Cannot remember what happened at a party--blacks out.

Requesting money more frequently from parents/friends or caught stealing.

Rumors are spreading about youth's partying or drinking.

Parents may have noticed their liquor supply at home is disappearing.

Family may have experienced an unusual amount of stress like unemployment, geographical move, loss of a child, or divorce.

There may be a history of alcoholism in the family.

An important point about teenage drinking is that it is usually episodic and binge drinking. This can be serious because of alcohol's toxic effect on the body. Overdose from alcohol can result in death, a serious side effect that many youths forget. Negative consequences of intoxication, like driving performance, accidents, aggression, and violence are cause for alarm because of its negative consequences on the youth's family and friends.

**b. Marijuana Use**

Disordered thinking or ideas and thought patterns that seem out of order.

Heightened sensitivity to touch, smell, taste.

Increased appetite after marijuana smoking (known as the "munchies").

Loss of ability to blush.

Decreased ability for rapid thought processes.

Weight loss.

Lack of signs of maturation, such as facily hair, muscle development, etc., due to increase in testosterone (male users).

Impaired motor coordination and perceptual ability to follow a moving object or detect a flash of light.

**b. Cocaine Use**

Runny nose, the tissue of which is at least irritated, if not scarred, from snorting.

Bloody coughs.

Needle marks.

Seizures.

Hoarseness.

Eyes sensitive to light, double vision, image distortion or floating spots.

High temperature.

Shakes.

Depression.

Extreme fatigue.

The drug user may be open or hide their paraphernalia depending on what drug(s) they are using. Paraphernalia may be as innocent looking as a Coca Cola can, a belt buckle, a pen, a Frisbee, feathers with a clip on the end, trays, aluminum foil, cardboard tissue paper rolls, miscellaneous nuts and bolts, mirrors, razor blades, straws, film canisters, matchbooks with burned spots, incense or aerosol deodorizers (used to mask smell of marijuana), or paraphernalia may look like plastic freestanding cylinders with small hoses attached (bong), toy space guns, etc.

Magazines, such as High Times, are published by pro-drug groups. They market paraphernalia and publish articles on gardening marijuana, how to get better highs, and they name celebrities who recommend drugs.

Marijuana seeds in clothing, automobile carpet or seats, or purse will signal marijuana involvement, as the seeds are not desirable for smoking and the user will try to sift them out before rolling a cigarette. There seems to be no limit to the kinds of paraphernalia used, so it is best to suspect and investigate anything that needs further exploration.

## ADOLESCENTS AT RISK: HOMOSEXUALITY

Another high risk factor for establishing suicide potential is homosexuality.

Teens who realize that they are homosexual (usually at about age 14) have a double whammy of dealing with the turbulence of adolescence and the realization of their sexuality. Generally, the teen's response to homosexual preference is shaped by the response of significant others to the homosexuality.

Suicide is the **leading** cause of death among young gay males and lesbian women.

Of the homosexual population, 20%-30% will seriously attempt suicide before age 20.

Over 50% of homosexuals experience moderate to severe depression.

The liberated community contends that as much as 20% to 30% of teen suicides may be due to homosexuality.

Most stories which have a homosexual character end with the unhappy person killing him or herself.

Homosexuality, generally, is regarded as sick, wrong, bad or helpless. Many homosexuals who do try to conform to heterosexual behavior fail and may become despondent.

Homosexual adolescents are forced to make a choice. They may choose to declare (open) their sexual persuasion or not (closed). Those who choose the latter have heavy internal conflict and cannot accept themselves for who they are.

**Those who choose to be open,**

face abuse
being thrown out of their home
rejected by family
unable to meet expectations of families
considerable harassment from 5th, 6th grade, up
50% of males and 20% of females experience physical or mental harassment
teachers are not supportive for fear of identification with the homosexual
social isolation and social withwithdrawal for fear of disclosure

**Many turn to:**

1. Substance abuse to reduce pain and inhibitions.

2. Professional help and find few therapists who recognize, accept or support homosexuality.

Many young gay boys and lesbian girls encounter their first crisis upon involvement with a lover. Their previous needs for love, care and affection are foisted upon the lover and inevitably are disappointed as the lover cannot meet the demand.

They tend to leave home early. Many turn to prostitution to survive.

If the homosexual is of a minority group, then double discrimination is felt.

Homosexuals can lead stable, happy and productive lives. They need accurate information, sensitivity, love and support.

The answer to primary prevention of suicide lies in the social sciences, rather than the biological sciences. The problem with finding an answer in the social sciences is that as soon as an answer to a question becomes known, then the fabric from which it is woven becomes different.

An example of this can be found in the closet thinking about homosexual behavior. When young people are called "faggot" or something similar, there are factors at work. This is such a common occurrence that many teachers, counselors and so on will not even correct or intervene when this name-calling is going on.

The young person who is called a "faggot" may be worried that he is gay or she is a lesbian and this may cause further distress.

At the same time, when the action is not corrected, then by their silence the young people regard the adults as condoning the behavior and condoning gay or lesbian life. In other words, the derisiveness of being called a gay name has been validated by the staff.

If, as part of an ideal society, all sexual persuasions were acceptable, the recognition of homosexuality would not be a concern for young people.

## RISK FACTORS

Youth who are at risk are those who are either impulsive, homosexual, depressed, abusers of drugs and/or alcohol, runaways, homeless and/or abused children (sexual or physical), products of broken homes, or displaced youth (military or recent geographical move). Many of these factors contribute to youthful suicide. The early recognition of depression and substance abuse may help reduce the number of suicide attempts.

Depression is more frequently exhibited in girls. Further, depression is more closely associated with suicide in adults than adolescents. However, in order to distinguish adolescent depression from depression/suicide potential, distress signals for depression are included in this publication. Depression is exacerbating and should be clinically treated if it becomes chronic, or the teen seems out of touch with reality or associated with any signs of suicidal behavior.

Depression is so common among adolescent girls that it is difficult to distinguish clinical depression and normal moodiness at this age.

## PERSONALITY TRAITS

How an adolescent has learned to cope with life will influence the risk of suicide. Impulsive responses, if habitual, may happen once too often.

How is stress met? Fight or flee responses are significant.

Aggressive, antisocial or behavior disorders are significant symptoms.

How does the family habitually respond to "bad break", sad events, etc. Are problems met head on and solutions sought, or is there a tendency to hide in some type of acting-out behavior or retreat?

Risk factors, behavior patterns and personality are the three major symptoms to explore.

## SUMMARY OF SUICIDE FACTORS

**Risk factors include:**

male
intelligent
age
previous attempt
family breakdown
family alcohol abuse
history of depression

**Behavior patterns include**

anger
depression
antisocial
chemical abuse
isolation
impulsivity
psychosomatic symptoms
humiliation
recent poor grades
homosexuality
eating
sleeping
change in self-care
getting things in order
self-destructive acts

When risk factors are combined with behavioral patterns and coupled with life space stresses, suicide is more likely.

**Psychosocial stresses which influence suicidal thoughts include:**

1. school change
2. personal injury
3. grades
4. arguments with parents
5. breakup with girl/boyfriend
6. trouble with brother/sister
7. change in parents' financial status

**More aggressive behaviors are noted in the suicidal population:**

Fights
Violent outbursts
Chips on your shoulders
    Example: crying or complaining
Denial - joy-riding, partying
Avoidance disorders or behaviors
    Example: family
             school
             physical activities

Intervention--do seek help more often,
             do use prescriptive
               drugs

**SOME WEIGHING OF RISK ASSESSMENT IS POSSIBLE**

1. How prevalent is the identified factor or constellation of factors?

2. How strong a pattern does the factor carry?

3. How readily can adults reach the identifiable group?
   For example, sexual abusers are not easily identified nor able to be reached with ease.

4. How receptive will persons be to intervention?
   Example: Some Eastern cults may have a different regard of suicide. Some ethnic groups may deny its existence completely.

5. How good is the intervention/ prevention method?

## CONTAGION EFFECT

Beyond the risk factors previously discussed, school personnel are becoming increasingly aware of the phenomenon of so-called cluster suicides.

If a suicide or attempted suicide is by a student, several forces are at work. If the victim is pretty well obscure, the notoriety of the act catapults him/her right to the number one topic of conversation. The person is instantly the most popular student in the building--sometimes posthumously. This has appeal for some students who are feeling like nobodies. The larger the school, the greater possibility for this type of imitation.

If the student is popular, then the appeal may be affiliation.

Most teens have romanticized death and do not think of it as a final act, but rather as an opening scene when it is imitative.

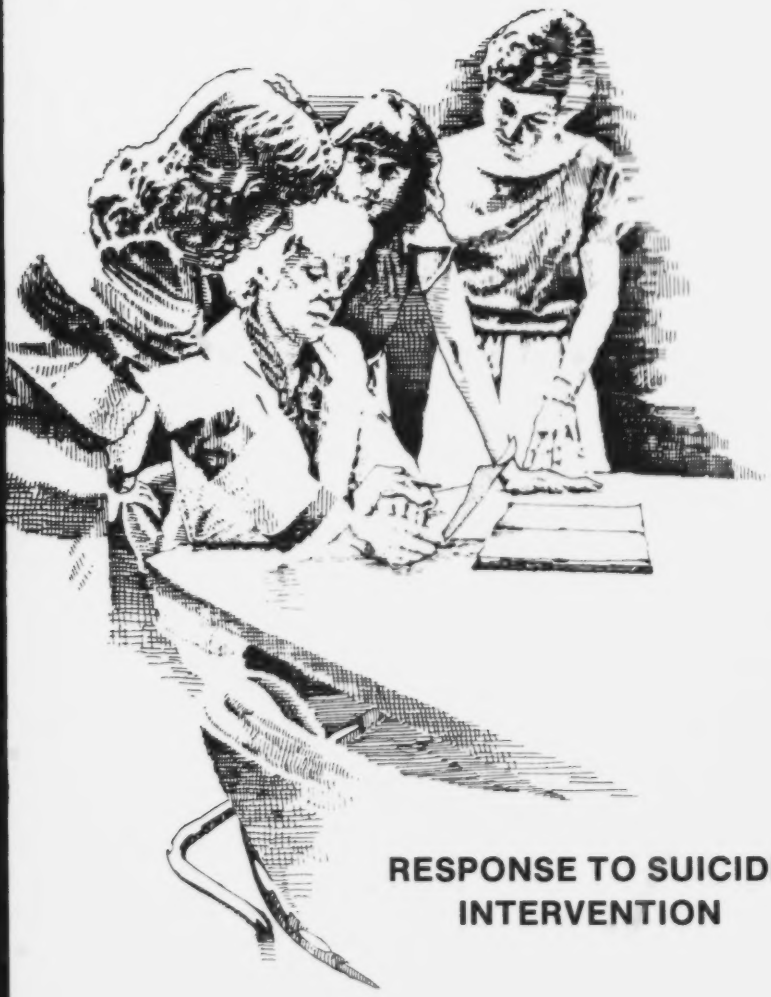
If a prominent person, particularly a teen or teen idol, has committed suicide, there is a chance of imitation (Appendix B). The risk increases with the prominence given to the act, i.e. front page versus inside section of the newspaper, lead-in on television.

There is evidence to support that the less glamorized a suicide is, the less likelihood for imitation.

In all cases, the increased possibility is greatest in the ten-day period following the incident, after that suicide attempts seem to revert to normal levels.

There is inconclusive evidence to support that the same phenomenon is true when it is related to television shows. Research in several major cities reported that the increased occurrence was true after the viewing of several productions, but another presentation seemed to have little effect.

Nevertheless, school staffs should be alert to the impact of copycat suicides.



## RESPONSE TO SUICIDE INTERVENTION

# RESPONSE TO SUICIDE
## Intervention, Prevention, Reaction

The response to suicide may be divided into three sections: intervention, prevention and reaction.

Intervention is classified clinically as primary prevention. It is an immediate response to a life threatening situation, usually involves the potential suicide and a small number of school staff.

Prevention addresses long-range answers to a very critical issue and involves most or all students and staff.

Reaction suggests guidelines for school administrators and staffs immediately following a suicide.

Although youth suicide is a societal problem, it is inescapable that schools will have to deal with it. For one reason, it is the humanistic thing to do. Another reason is that schools, by their nature, have a captive audience.

## INTERVENTION

The issues raised for primary prevention are that they must

1. Seek to reduce the incidents of suicide.

2. The timing of intervention, for example immediacy.

3. Intentional
   Example: the act of suicide must be imminent. The person must have means available and intend to carry the threat through.

When an adult or group of adults is looking at who to delegate for primary prevention, there is very little in research to pinpoint exactly who the person or persons are who are determined to take their own life.

Life is relatively short for all of us. Occasionally there is an inability or refusal on the part of a young person to accept some of the events of the human condition. It is extremely difficult to answer the question, who do we delegate? It is a huge task and the factors which influence the solution seem almost paralytic, rather than enabling. There is no specific etiology that is predictive of suicide with accuracy. It is a fact that life is full of ups and downs, joys and disappointments. Yet, most teens will not kill themselves or attempt to do so. What is it, then, that sets apart the group who does this awful thing from those who have learned to roll with the punches. Under the rubric of primary prevention are included: the teen must be predisposing, perceptive of death and ready to act immediately.

While there are many factors which might be considered in one's predisposal to committing suicide, there is one which should be weighed significantly more than others and that is **means**. A gun makes a dramatic statement and is usually lethal. However, a knowledge of firearms sometimes is a factor. Example, a .357 magnum is more lethal that a .22.

Suicide must be considered as an extreme acting out behavior, injurious and perhaps revengeful or a dramatic statement.

Members of the task force investigating the predisposing factors which cause young people to kill themselves tried to do the same thing for young people who do not kill themselves. The idea was that if there could be some common pathway used by those who did not kill themselves, could what was learned be applied to the high risk group?

This group recognized a cluster of symptoms as being predisposing:

**existing depression**
**not belonging--to a group or crowd**
**lonely**
**highly stressed**
**school failure--or perception of same**
**attention paid by others to a suicide victim**
**accessibility to a means**
**attractiveness of publicity**
**developmental factors**

Example: In a small school, everyone has a place in the societal hierarchy, even sometimes an unwanted one. In large schools where anonymity is more likely, there is a greater incidence of suicide attempts.

**Crisis intervention should include:**

1. continuous monitoring
2. links to adults
3. establishment of networks
4. assigned tasks to teen
5. involved parents
6. rank problems
7. priortize solutions
8. solidification of contracts
9. mandated follow-up

Depression reflects a temporary state, is usually brief and dependent upon the state while the teen struggles to regain control of his/her life.

## School Involvement

School personnel are in a unique position to contribute to the positive development of youths. Often teachers and other staff are the confidants of students. They may know of problems kept from or disguised in a family setting; they may observe behavior changes; and they are aware of the range of normal adolescent social behavior in and outside of the classroom.

Teachers and other staff need to be aware of the direct and indirect signals that a student's behavior is self-destructive and perhaps suicidal. Knowing these behavior patterns and cues may help a teacher respond in positive and productive ways to a potential or actual adolescent crisis. The faculty member may help the student master a crisis, thus averting self-destructive behavior.

Having identified one or more symptoms in a student, there are a number of ways to respond. The most basic is to communicate concern both about a youth's self-destructive behavior and his or her physical and emotional well-being. Often teenage communication needs emotional de-coding. It is best to stay with de-coding efforts until the youth indicates that he/she is understood.

**THE FIRST STEP IN THE INTERVENTION PROCESS IS TO IDENTIFY A SCHOOL CRISIS TEAM. THE BUILDING PRINCIPAL AS THE LEADER OF THE TEAM WILL DETERMINE WHEN IT IS APPROPRIATE TO ACTIVATE IT.**

Of particular impact for educators listed by psychiatrists is that of the ten highest child stressors, six are school related, some of the six relate to competition and expectations for excellence. There is a need for educators to create a climate which is supportive and emotionally healthy for young people while helping them learn. Schools should be the conduit for better mental health practices, starting with expectations and ending with homework.

What can school personnel, students, and parents do to change the tide of youth suicide? Initially, they can be alert to the cues to suicide. Distress signals are youths' way of letting others know they need help. Seldom do young people recognize their own difficulty or bother to consult with adults. What teens do is send out camouflaged signals. Adults need to recognize the importance of those signals. Youths need to be confronted regarding observations. Observations need to be validated with a member on the crisis team and, if indicated, help obtained for the youth.

The distress signals included in this booklet are not listed in hierarchial order. It cannot be said that one signal makes a youth suicidal. There is never just one thing that brings about a suicidal episode, but a combination of factors. The loss of a loved one like a boyfriend or girlfriend, failure in a class, rejection from a group, argument with a parent, and/or trouble with the police may be catalysts for suicide attempts. Loss, real or perceived, characterizes the youth's life. The youth needs help. If parents, peers, and school personnel learn to identify these distress signals, an impact may be made on youth suicide.

## SUGGESTED PROCEDURES FOR THE CRISIS INTERVENTION TEAM FOR DEALING WITH REFERRALS RELATING TO SUICIDE

**Suggested Procedure**

If any Board of Education employee determines that a student is planning suicide, the following procedures will apply:

1. **Report any potential threat or suicidal student** to a member of the crisis team (psychologist, guidance counselor, nurse, social worker/ substance abuse counselor and, **always**, the school administrator).

2. **A member of the crisis team** (psychologist, guidance counselor, nurse, social worker, or administrator), in collaboration with another team member, **shall be responsible for determining the seriousness of the threat.** In the case of a life-threatening situation, the student and the staff members involved must understand that the issue of confidentiality shall no longer apply.
   a. Question the student about any feelings of hopelessness and the length of time of such feelings.
   b. Question the student about any thoughts about killing himself/ herself and discuss the persistency and strength of the thoughts.
   c. Question the student to determine whether any plans have been made, the details of the plan, and whether any preliminary actions have been taken. Determine lethality for suicide.

**DO NOT LET THE STUDENT OUT OF SIGHT!!!**

3. The parent must be notified immediately!

4. The student may only be released to a parent/guardian, law enforcement official, or emergency medical staff.

5. Make the parent aware of sources of help. It is useful to have a resource guide to give parents or guardians. Encourage them to obtain help.

6. **Follow up** to be sure that some contact has been made for help. It is helpful to have a follow-up form made to send where referrals are made. Obtain permission from the parent or guardian for the release of information, as many agencies cannot discuss problems with school personnel without parental/guardian permission.

Once a potential suicide is suspected, the best approach is to confront the problem. School personnel should ask, "Have you been thinking of harming yourself? Ideas will not be put in the youth's head and chances are he/she will answer you honestly. By using basic interviewing skills, adults should try to answer the questions of who, what, when, and where. In suicide assessment, it is important to know **how**. The "how" answers to the **availability of means** to commit suicide and is very important. For example, if a student says that he/she has a gun at school, help from the police department should be requested.

**When a teenager is suspected of being suicidal, remember five things:**

1. Discuss suicide openly and frankly.

2. Show interest and support. Communicate that you care and that you are trustworthy.

3. Get help (validate with someone you know who has some knowledge of suicidal behavior).

4. **Assess lethality:** A firm plan to killing oneself is serious, particularly if actions have been taken to carry out the plan.

**IF YOU DETERMINE A STUDENT IS SUICIDAL**

5. **DO NOT LEAVE THE STUDENT ALONE... UNDER NO CIRCUMSTANCES! YOU WILL NEED TO TAKE CONTROL OF THE SITUATION UNTIL YOU ARE CERTAIN THE STUDENT IS SAFE...THE STUDENT HAS BEEN TURNED OVER TO PARENTS, THE LAW, OR A MENTAL HEALTH PROFESSIONAL. THIS CANNOT BE IGNORED AND SHOULD BE ADHERED TO RIGIDLY.**

**The Issue of Confidentiality**

You may be faced with a confidentiality dilemma. Youngsters often will share highly sensitive, personal matters with adults if they promise not to tell anyone. It is easy and very tempting to enter into such an agreement; however, taking this approach is very dangerous. In these instances, teenagers want to tell adults their concerns and want their help. Their ambivalence is expressed by their desire to have the adult know and, at the same time, tie the person's hands to do anything about it.

The best approach in this situation is to let the teenagers know that if what they are about to tell is anything which could involve their harming either themselves or others, it is the responsibility of the counselor to seek help. The teenagers are asking for help because there is some degree of trust between the adult and them. Acting in a responsible manner reinforces that trust.

**Present options,** options from which teens can choose and still maintain dignity. For example:

1. "You can call this number (mental health crisis line in area) while I'm here with you."

2. "I will call the crisis line and share my concern of you." or

3. "I will need to speak with your parents to see if we can work this through."

**Basic Strategy**

1. Be calm and affirmative.

2. Connect with the youth and build a relationship, but know the ultimate decision to live or not to live is the adolescent's. Recognize that ambivalence characterizes the suicidal adolescent. They have as much will to live as they have will to die. The crisis team member needs to make the teen want to live.

3. Listen and reflect back feelings to help the adolescent feel that someone has heard his pain.

4. Be nonjudgmental about values, beliefs, or behavior.

5. Acknowledge the reality of suicide as a choice but explore other alternatives.

6. Acknowledge the person's feelings of helplessness and discuss alternatives to suicide.

7. Instill hope and buy time.

8. Prioritize problems and plan action steps.

**School personnel should use the following techniques <u>when appropriate</u>:**

1. Express appreciation for being with the person (ex., "I want you to know that I appreciate your being with me right now.").

2. State concern about the teen's welfare (ex., "I've been worried about you lately.").

3. Give nonjudgmental feedback about the teen's behavior (ex., "I've noticed that you aren't sleeping much; you're losing weight; you have withdrawn from people, groups, etc.; you're skipping school; you seem depressed and sad, etc.").

4. Confront the concern that the teen might be thinking of giving up on life (ex., "I guess I wonder if you are thinking of giving up on life....or perhaps ending it all.").

5. Use themselves as an example, only if it is true (ex., "When I've been really down and desperate, I've thought of giving up, too. It sounds like you might be feeling that way now").

6. Normalize **thoughts** of suicide (ex., It's common for people to feel so helpless and hopeless sometimes that they think about ending their life. That doesn't mean that you have to act on it. Most of us think about that from time to time.").

7. Ask how the teen might go about ending his/her life (ex., "If you ever were to really try to harm yourself, how would you do that? Have you thought about that?"). If the teen knows how he/she would do it, the person is more at risk than if no plan is premeditated.

8. Ask if the teen has the gun, rope, pills (ex., "Do you already have a gun?" or "How would you go about getting it?"). An available method to end one's life and the plans to do it are very serious.

9. Ask if the teen thinks the method chosen will really solve the problem (ex., "Do you believe that will kill you?"). You are trying to determine how much the adolescent knows about the lethality of the means chosen. For example, if he/she has a gun and bullets, there is more risk than a person with 20 aspirin who is not sure if that is enough to cause death.

10. Ask what event precipitated the immediate crisis. (ex., "What happened that finally was the last straw for you?").

11. Reflect back to him/her the feelings you hear behind the response (ex., "Sounds like you're feeling rejected... sad...alone...humiliated, etc., right now. You feel as if no one really cares for you").

12. Ask if the teen has ever felt this way before and, if so, what did he/she do then to feel better (ex., "Have you ever felt this way before?" If the answer is yes, "What did you do then to take care of yourself and to feel better?"). Explore the young person's own resources and strengths used in the past.

13. Ask, "On a scale of 0-10, if '0' is the worst you've ever felt, and '10' is the best, where are you right now?"

14. Ask, "If you really did end your life, I wonder who you'd want to find you?" (Most suicides involve the relationship with one other person, at least as a precipitating factor, so try to identify that person.) Explore that relationship and any sense of loss involved.

15. Ask about the teen's support system--friends, family, etc. (ex., "Who would you like to have with you now?" State, "It's important that I call in someone to be with you right now. I need to call in your folks."). State affirmatively that the teen needs to connect with those people who care and who can help the teen deal with this.

16. Share themselves and their resources (ex., "I have a consultant who helps me when I'm stuck."--you are role-modeling here--"I need to touch base with that person in order to take care of me, to give me support when I feel hopeless.")

17. "I will call your....(parents, friend, relative, minister, etc.)."

18. Take charge if it is serious. The teacher, counselor, school social worker, etc. may say, "I will participate in your life, not in your death. For now we will do this....."

19. Do not leave the youth alone. Call a resource person (family, friend, etc.) in the teen's presence so that he/she will not feel betrayed. Most young people want you to take charge.

20. Wait for the resource person to come and share your concerns with the resource person in the presence of the suicidal person.

21. Make referral to: mental health center, psychologist, psychiatrist, hospital, or release the individual to the care of the parent, impressing upon them that the young person needs help--or accompany the teen to the hospital.

22. Know that everything has been done to handle the crisis, and take credit for being willing to risk with the teenager. Be sure to talk to a consultant about the situation to get support after the crisis is over.

A Lethality Assessment used by the Suicide Prevention Center of Dayton, Ohio, (Appendix C) may be used as a model but is not inclusive of all symptoms.

**Intervention techniques adapted from the Link Counseling Center, Atlanta, GA.**

## ANALYSIS OF INTERVENTIONS AND PREVENTION PROGRAMS

Dr. David Schaffer, head of clinical psychiatry and pediatrics, Columbia University, describes research on preventive measures for teen suicide as thin in relation to space, time and depth. He had considerable research information that so-called hot lines do not work as well as would be supposed. There is no evaluative research on educational models or school programs. There is a great need for good research on suicide prevention models. There seems to be a great deal of activity but no research to back up effectiveness of prevention models.

The significance of this statement is that there is no guarantee that any one method of addressing youth suicide is better than another. At this point in time, the best course of action for school personnel seems to be to use the procedures suggested within these pages as guidelines. They are reasonable and most likely will be successful. On the other hand, there are some young people who are bent on destroying themselves and intervention is, at best, delaying the process. These lost souls will eventually be successful in their attempts despite best efforts of well-intended and knowledgeable professionals.

Dr. Schaffer described the population of suicidal adolescents in three ways:

"I wish I were dead";
attempted suicides; or
dead.

Statistics of suicide indicate that there are more attempts made by girls, while there are more fatalities for boys. The difference which accounts for the contrast of attempts to fatalities is, for the most part, due to choice of method.

**The following factors are remarkable:**

1. 40% of completed suicides have attempted previously.

2. 40 out of 1,000 teens may think about suicide at some time.

3. The severity of the attempt is not predictive of death.

4. Teens who have had an idea of suicide and attempters of suicide have similar symptoms.

5. TV shows which have included both attempted suicides and deaths seem to act as a stimulus to suicide, particularly if the chief character was an adolescent and famous.

6. Sex/method/outcome are confounded.

**Function of Method**

Less aggressive
females
overdoses
ineffective attempt
survives attempt
attempters

More aggressive methods
males
firearms
effective
completers
die

The young people who have an idea of suicide may go in and out of a suicide zone.

## RESPONSE TO SUICIDE PREVENTION

# PREVENTION

## Immediate

Predicting which teen may attempt suicide is difficult even for mental health therapists.

Teens have typical reactions to problems, pain and frustration. Students this age have three qualities in common: a rapid growth with chaotic mood swings, external and internal pressure and a distorted sense of time.

## Balancing Factors Needed

The balancing factor for chaotic teens is structure provided by the family. Structure should include parental responses which are based on clear-cut, rational grounds. The burden of structure and stability is clearly a family obligation.

Pressures to achieve are imposed by the need to know more information than ever before. Further, this generation may be facing a downwardly mobile society. Increasing acceptance of vulgarity and routine sexual exposure leads to the acceptance of sex as an outlet at an age too immature to accept consequences. Drug culture and pressure to experiment or not adds more stress.

These internal and external pressures need to be modified. Encouraging teens to achieve to their ability is healthy. Expectations of excellence in areas in which a teen may be average or weak is asking more than a young person may be capable of giving.

Exploration of careers which are satisfying may help teens generate realistic expectations.

Monitoring of media presentations available to even very young children is needed to re-establish true meaning of human sexuality.

Continuing programs of substance abuse information reassures young people that it is OK to say "no".

The last factor to consider in planning for students is time. Time is seen by teens only in its immediate dimensions. Time for the adolescent exists only in terms of now. If pain exists, the pain must be stopped now. Solutions must be immediate.

Interventions, therefore, need to be quick if temporary. Prevention and intervention plans must address stress and take into consideration the three factors operating in teens: rapidity of change, lack of stability and the immediacy of time.

## Suicide Is a Societal Problem

The only effective response to suicide must be a holistic approach. Good parenting, firm support systems, strong organization affiliations and an educational system which is sensitive to the needs of young people are all important components of a prevention program.

Just as suicide among young people is a community concern, the solution must come from the community. Schools are a part of the community and are pledged to address the issue, but prevention cannot rest solely on the shoulders of educational facilities.

Not all suicide prevention will take the form of crisis intervention. Some forms of prevention involve education and training. Adults and youths can profit from training in which behavioral cues are outlined and ways of helping are practiced. Such training must be offered within the context of institutional guidelines and personal concern for the physical, emotional, and intellectual well-being of young people. Training will provide a framework for understanding positive, as well as self-destructive, elements of adolescent life. Suicidal thoughts and actions may be part of a repertoire for some youths.

Schools can provide educational programs in the classroom and at assemblies which cover a range of issues and concerns about adolescent development. Perhaps a series of health-related discussions could be offered. These discussions could include such topics as eating disorders, drugs and alcohol, management of personal stress, as well as suicide clues and prevention. One advantage of a combination of training and discussions is that students and faculty will choose their own level of involvement and comfort with the subject matter.

Far less successful and more anxiety-provoking are prevention programs which rely on just one presentation with no follow-up or relativity within the institution. These programs tend to scare youths and faculty alike, and place an undue emphasis on suicide in the adolescent sub-culture.

Finally, institutions send powerful messages to their members by providing support and opportunities for emotional as well as cognitive growth. Peer counseling rap or personal growth groups, faculty in-service or teacher-institute training workshops, youth and adult leadership training opportunities are programs which suggest an institutional receptivity to the vicissitudes of the emotional lives of those serving and served by the schools.

## Community/Family/Schools

No combination of programs will eliminate suicide. Suicide is the most extreme form of self-destructive behavior, and always will be a possibility for some youths and adults. However, prevention programs and interventions offer an antidote to the profound feeling of helplessness, of feeling alone and out-of-control, experienced by some adolescents. These interventions do offer adolescents opportunities to rethink their situation and the choices they face, and for responsible adults to influence teenagers' decisions.

However fine programs may be, it must be stressed that the best way to prevent suicide is through mutual efforts of the community, family and schools. Working together for a brave, new world may seem a monumental task but why not "reach for the stars. What else is a heaven for?"

## SCHOOL PERSONNEL, STUDENTS, PARENTS: WAYS TO DEAL WITH THE PROBLEM

Adolescents who kill themselves are at their rope's end. Adolescents who attempt to take their lives are characterized by a combination of longstanding problems and the impact of a recent precipitating event. In a recent study, 52 percent of precipitating events involved problems with parents, 30 percent involved problems with the opposite sex, 30 percent involved problems with school, 16 percent involved problems with brothers or sisters, and 15 percent involved problems with peers. Only five percent of the adolescents displayed psychotic symptoms such as disorientation, hallucinations, or thought disturbances. Further, school adjustment can be a precipitating factor--poor grades, truancy, and disciplinary problems at home or school. Schools may want to consider implementing the following preventative measures:

**A. School Personnel**

1. In-service training on **adolescent stress** and how to help alleviate it in a school environment.

2. In-service training on the **signs and symptoms of depression, substance abuse, sexual and physical abuse, and cues to suicide and other handicapping disorders.** Emphasis should be placed on early identification of students at risk for problems. Referrals can be made to the crisis team and follow-up of referrals needs to be done. Educators can become better observers of students' behaviors, more supportive of them, and can do less labeling of deviant behavior when it occurs in their classrooms.

3. Delegate the leadership for implementing a youth suicide prevention program at your school to a **crisis intervention team** selected from willing and qualified faculty. The team may consist of administrators, guidance counselors, school psychologists, nurse, social workers, or qualified teachers. Sometimes a supportive staff member like a secretary may be very effective on a crisis team, particularly if he or she has been trained.

   a. Select <u>one</u> member from the team (preferably by the team) to be the team's formal leader. However, the building principal will always have the final say in activating the team and approval for implementing a plan.

   b. Educate the team members about crisis intervention techniques. Crisis intervention is **not** psychotherapy but the restoration of students to their former emotional/behavior states.

c. Emphasize the importance of follow-up of referrals. A large number of students at risk never receive help, although help is desperately needed and often desired. A school procedure needs to be decided concerning students who refuse help or who are unable to receive needed help because of finances or parental cooperation.

4. **Develop written procedures** for dealing with suicidal or depressed youths. A written procedure on how to deal with a youth you suspect is abusing drugs is very helpful. Procedures may include:

When and how to refer to the crisis team

When and how to inform parents

When and how to inform administrators

When and how to counsel the youth

How to obtain an assessment for lethality

When and how to refer the youth to a mental health center

B. Students

1. **Health curriculum** for every student with the following suggested topics:

   a. Positive self-esteem...an "I'm okay, you're okay" focus.

   b. Effective interpersonal skills with peers and adults--getting into, maintaining, and terminating relationships. Learning social skills for dating and school activities can be beneficial.

   c. A positive attitude toward loss, failure, and grief. Learning how to fail is as important as learning how to succeed.

   d. Life skills--decision-making, values clarification, and problem-solving.

   e. Stress management skills.

   f. Substance abuse and its effects on the body.

2. Consider developing a **peer support program** (sometimes called peer counseling).

   a. Problem-solving with a peer. (Note: The National Youth Suicide Conference emphasized avoiding the phrase "peer counseling" as it can be misleading to students. It is recommended that peer counseling be called peer support and the focus should be **supportive**.

   b. Self-help group for maltreated teenagers and for those students needing a group experience, e.g., whose parents are going through divorce or who have suffered the death of a parent).

C. **Parent Training**

1. A workshop can be held at school to educate parents about youth's substance abuse, depression, and suicide. The workshop can focus on ways to prevent youth suicide and describe the relationship between substance abuse, depression, and suicide.

2. Educating parents on how to have effective communication with teenagers.

D. **Indirect Education to Students and Faculty**

1. Newspaper articles placed in school newspaper.

2. Presenting school plays or showing films on the problem of youth suicide and following up with resources for help.

In summary, an effective suicide prevention program in school buildings depends on the participation of students and parents in all aspects of the program. There are a multitude of excellent parental and student resources in every building. By involving parents and students in the program and delegating the responsibility to a trained crisis team, half the problem of youth suicide is conquered. The other half involves community support. Support services for youths need to be identified. Further, the maintenance of a collaborative relationship with community agencies involved in suicide prevention, education, and intervention is important.

## PROGRAMS WHICH ARE EFFECTIVE

Treat suicide as a thievery of life.

Provide psychological and physical first aid.

Have a crisis team in place.

Have an administrative policy--if a suicide is imminent, how is it treated?

Physical resources--sufficient meeting places, materials and phones.

Support agencies can serve as consultants, referral sources, and trainers of staff and students. By maintaining a collaborative relationship, follow-up of referrals can be better realized, particularly if there is a mental health liaison person at each building (leader of crisis team). A list of community mental health centers is included in Appendix D.

Prevention and intervention programs which were the most successful all included a home visit. There is a whole lot to be found out about family dynamics when one enters the house. The other advantage of a home visit is that the appointment will be kept.

Prevention programs also have a better chance of success if the prevention sessions are not called therapy but rather something else, such as coping skills. This removes the stigma of treatment and lessens the apprehension that something is terribly wrong with the individual. Most young people contemplating suicide think that this may be the case and certainly do not want it confirmed.

Prevention/intervention programs treatment have to be more user friendly. The closer the treatment is associated with the schools and the educational program, the more chance there will be of success. The ideal program would involve a consortium of school, support personnel and agencies.

School programs and/or treatment programs should be designed to teach coping skills. Young people need to know what their strengths are and what is going on in their life that they can classify as good.

Suicide prevention by mass media needs to be informational and directional. The media is not the cause of suicide, nor can it be expected to correct it by a series of public service announcements. Public service announcements can, however, emphasize one of the risk factors of suicide which is access to a lethal weapon. An interesting statistic supported this idea. For every time a hand gun is used in the U.S. in self-defense, it has been used 44 times to commit suicide.

## SCHOOL-BASED PREVENTION PROGRAMS

Dr. Garfinkle, Director of Child and Adolescent Psychiatry at the Mayo Clinic, described the ideal school intervention/prevention program as including the superintendent, building administrators, teen leaders, counselors, school social workers, nurses and psychologists.

**Programs should include**

Early identification screening of high risk students
Comprehensive evaluations
Crisis intervention teams and programs
Grief programs
Education for and management of staff
Community networking/advocacy monitoring
Evaluation
Coping skills
Prevention
Intervention
Aftermath

Affective education needs to focus upon teaching students how to cope with stress and teaching teachers how to reduce stress. The general ecosystem of education needs to include general health and well-being. Students need to be taught problem-solving strategies and coping strategies.

**Staff working with young people need to improve skills:**

1. How to identify students who are high risk.

2. When are antecedents sufficient for alarm?

3. How can we draw on general fund of information to help?

For adults who work with young people, there is a paradigm of being familiar and comfortable with intervening and frequent behavior patterns, such as substance abuse as opposed to dealing with infrequent behavior patterns, such as suicide prevention.

There is a need to develop programs which are interactive and which use a generic, rather than specific approach to intervention.

## RESPONSE TO SUICIDE
### Reaction

# REACTION

Joseph Solanto, Ph.D.

The following outline presents a compilation of several Westchester/Putnam, N.Y. school districts' responses to student suicides during the 1982-83 and 1983-84 school years, and was modified by Grosse Pointe committee members in 1986. This is not to say that it is theoretical, since each step has actually taken place in one or more schools. Recognizing that each school and community is unique and possesses its own special resources, it is hoped that this model will serve as a springboard for discussion and planning in order to tailor it to each district's particular needs. The model may be adjusted to address suicide attempts or events viewed as emotionally catastrophic by the administration of a school or organization.

**Reaction** (Continued)

It is important to note that this chapter should be treated as a guideline and adjusted appropriately to the event, time and organization.

An essential element of every procedure is that it be in place before the need to use it. Identifying a crisis team is an administrative responsibility. The principal of the building will decide when it is appropriate to alert team members.

The following pages detail each step of the procedure to address the aftermath of suicide.

**After a suicide:**

1. psychopathology of the suicide should be stressed
2. teens urged to break identification
3. de-emphasize the suicide
4. identify stressors
5. limit memorialization

**Initially:**

Adolescent found dead of an apparent suicide. This usually occurs after school hours or on weekends.

After verification of details, school principal initiates chain call to all staff to inform them of the tragedy and to ask them to arrive at school 30 minutes earlier in the morning to attend a special staff meeting. This notification reduces the possibility that staff will arrive in school totally unprepared. Teachers who were known to be particularly close to the student should be given an opportunity to join a support group.

Administrators, guidance and clinical staffs meet or have telephone conference to plan the activities of the next day, to allow for the expression of feeling and to lend support to each other.

Initiate fan-out phone calls to all public, private and parochial schools since many have relatives or close friends in these other settings.

**Additional Suggestions**:

Assign one school authority to interact with the media. Sensitivity to parents' position needs to be exercised to ensure honest reporting and respect the wishes of the family.

The principal, along with a guidance counselor and/or clinical staff person should visit the victim's family at home. In addition to expressions of sympathy and support, plans for a memorial service at school can be made, and advice given about dealing with the student's close friends. Also, any of the student's personal belongings from lockers, etc., can be returned. Although this procedure seems harsh, the family is usually anxious to look through a youngster's collection of articles to see if there may be a note.

School records of the deceased should be gathered and given to the principal. The student's name should be deleted from any data banks to prevent later mailings being delivered to the home.

**Day One**:

Early morning staff meeting with several purposes: Principal reviews the known facts of the case, in order to establish a common reference base and to dispel rumors. The administrator then announces the schedule and events of the day.

School psychologist or other clinical staff person describes the feelings which the students may be experiencing and suggests how the teachers might handle these. Time is allowed for questions and dealing with the feelings of the staff. Some staff members may be particularly upset and require additional support.

A crisis center is established in the guidance office. Additional pupil personnel staff from other buildings and from neighboring school districts may be called in to assist.

**Day One** (Continued)

Teachers are encouraged in whatever way they feel comfortable to allow for the expression of grief in their classes. The guiding principle is to return to the normal routine as soon as possible within each class and within the school.

The principal, guidance counselors, and clinical staff meet with students and individual classes to:

Review the known facts and to dispel rumors.

Inform students of the crisis center.

Encourage students to express their reactions in whatever way is appropriate for them. (All responses are acceptable, from severe upset to no reaction whatsoever.)

Discuss possible guilt, feelings of responsibility, or fears.

Ask students to be supportive of one another and to escort any friend who is upset to a teacher or the crisis center.

Reassure students that any adult in the building is available to help.

Encourage students to discuss their feelings with their parents.

**Day One** (Continued)

The teachers are asked to dispel rumors wherever possible, and to discourage any glorification of the event. For example, if a student is heard to say, "I wouldn't have the guts to kill myself!", the teacher can respond, "Suicide is not a brave act! It is far more courageous to go on living and to face your problems each day as you and I do."

The staff is asked to plan for a faculty meeting immediately after school to review the events of the day.

"Peer Counselors" are identified and assembled. A school social worker or staff psychologist helps these students work through their feelings. Peer counselors are offered guidelines for helping their troubled friends and/or escort them to a crisis center.

**Day one** (Continued)

Phone calls are made to parents of individual students who are particularly upset during the day. This is ideally handled by the clinical staff who can explain the student's reaction to the parents and give appropriate advice as to how the parents may help their son/daughter.

Building staff are assembled after school to:

Allow for the expression of feelings and for mutual support. After a full day of dealing with their own emotional responses and that of their students, the teachers are generally quite drained.

Review the events of the day.

Review the characteristics of high-risk students--those who seem especially upset or depressed or show other signs of not coping well. Compile a list based on staff observations of individual student reactions during the day.

Announce funeral arrangements and encourage staff to attend, if possible, in order to provide support to students and their families.

**Day Two:**

**Outside consultants** are called upon. At this point it is helpful to have outside professionals because they are not emotionally involved and can, therefore, provide objective support and direction. Some of the services they provide are:

Professional consultation for individual students.

Speak at a general faculty meeting on the issue of adolescent suicide: identification, prevention, response.

Conduct evening informational meetings for all concerned community members.

Guidance and clinical staff continue meeting with individual students and small groups to provide support, and to further identify high risk students.

**Day Three**:

Phone parents of students identified as high risk. Invite them to a special evening meeting.

Outside consultant and school staff conduct an evening meeting of all parents of high-risk students. The consultant urges each family to pursue an evaluation for the teenager at one of the public or private mental health agencies listed in a handout. Guidance and clinical staff are available to answer privately parents' specific concerns about why their son/daughter was so identified.

**Day Four**:

Guidance and clinical staff continue crisis intervention, answer phone calls of anxious parents, and meet with concerned staff.

Front-line staff who have been involved directly with the crisis meet with a consultant for expression of feelings and mutual support. **THIS IS A VERY NECESSARY INGREDIENT.**

**Finally**.....

Shortly following the funeral, a memorial service during the school day may be conducted. This is a voluntary service for any student or staff member who wishes to attend. Neither the student, nor the act is glamorized. In fact, frequent reference to this act as "unwise", an error in judgment, etc., is made. This service should serve as the institutional signal that the official period of mourning is over. Future memorials, such as trees planted in memory, plaques, etc., may be permitted. This helps the student body to bring closure to the event.

These crises require that administrators and staff reach out for support from colleagues in the educational and professional communities. Get as much assistance as necessary.

**Finally** (Continued)

If a suicide occurs in a neighboring school, the administrator should not hesitate to call or drop a note to offer support to a counterpart. Sometimes administrators may hesitate to do this, but it is a gesture which is greatly appreciated.

Make every effort to involve the PTO and community leaders as soon after the tragedy as possible. This is a community concern and should be addressed at the community level. The problem is societal and the prevention of suicide is many faceted.

**An Ongoing Program**

The work is not over at this point in the process. Ongoing contact with students, parents and staff is often required for many months after the tragedy. Some experts tell us that the aftershocks may reverberate in the district for two to three years.

Periodic re-evaluation of the grieving process is recommended.

## Community Response

Everyone should reach out to a family that has experienced a suicide.

The family can better make their way through the grieving process with openness and support from others.

Healthy interaction will start the healing process.

Establish a support group to enable sharing of grief with others in the community.

The bereaved could share their feelings without fear of being blamed or lectured.

Others in the group will be supportive.

Sharing grief with others will hasten the resolution of acute grief.

Publicize community resources for support and/or counseling to facilitate healing for the bereaved.

**Support Groups**

Grosse Pointe War Memorial has a group called "New Beginnings" for persons coping with grief.

Check churches who may have short-term groups for people going through grief.

**Available Telephone Contacts**

Detroit Survivors of Suicide:
Call anytime, 224-7000.

Bereavement Resources, 24-hour
line: 224-1951.

**Counseling**

Professionals in private practice
will provide therapy for grieving
clients.

Community Mental Health Centers work
with individuals and families expe-
riencing adjustment problems after
a death.

School social worker can provide
direction to outside therapists.

**Aftermath for Staff**

It is important to remember that after a suicidal crisis, staff members may feel very tired or "washed out." They should discuss the situation with someone they value and trust. In clinical situations, this is a time to go over what was learned. It can be a time for mutual sharing and support of one another.

Many times suicidal teenagers are manipulating and begging for attention. This can be a problem to a teacher. However, the student's need for attention ought to be addressed by a mental health professional, not teachers. A teacher's role is to pay attention to **distress cues** and not be concerned about manipulation... every hidden message that a teacher/counselor suspects might be a cue, needs to be validated. Also, do not believe that a suicidal crisis is resolved after one session. Be leery of potentially suicidal students who say that everything is okay now...they may have decided to kill themselves.

Included in this booklet is an assessment tool that may help determine students at risk in classrooms. This observational tool may be used by all faculty.

## ISSUES FOR SURVIVORS

Curtis Mitchell, Health Editor for Reader's Digest and for Health magazines, gives some insight for survivors.

Survivors are everywhere. One normally associates the immediate family as being identifiable survivors. However, everyone who in the least way is associated with a suicide becomes a survivor. There is no depth to the pain, surprise or shock experienced by close survivors.

Survivors should

1. **Refuse to accept the stigma.**
2. **Rid themselves of notion of responsibility.**
3. **Free themselves of violent thought.**
4. **Forget about "if only".**

Survivors should

1. **Keep active.**
2. **Join groups.**
3. **Discuss their hostility**
4. **Find a motive for their life.**

Hopelessness cannot turn into hope unless there is an active desire to do so.

1. **You can survive if you want to.**

2. **Every member of the family must be included in family discussions or decisions.**

3. **Look hard enough for good. Good might be elusive, but it will be eventually found.**

Suicide brutalizes a family; if they are Judeo-Christian the sorrow quickly turns to pain and guilt. Many survivors are in a state of denial. They seek refuge in fantasy: "It had to be an accident". Many survivors feel that they are condemned to lie about the incident for the rest of their lives. When counseling a survivor, it is important to stress with them to be honest about the incident and up front about the known facts. Many women survivors are overprotected by males and there should be a concerted effort to stop this practice. The survivors need to know that the source of strength is within themselves.

It is important to remember that friends, classmates, relatives, and teachers should all be considered survivors.

# RECOMMENDATIONS

## SUDDEN ADOLESCENT DEATH COMMITTEE RECOMMENDATIONS

The committee studying the Sudden Adolescent Death phenomenon has published a booklet containing some preventive measures to be followed by schools and a plan for addressing the aftermath of suicide.

In addition, the following recommendations were offered by the committee to the Grosse Pointe Public School System Board of Education:

1. The report, **Sudden Adolescent Death** be accepted by the Grosse Pointe Board of Education.

2. The booklet published by the Committee on Sudden Adolescent Death be made available at no charge to administrators of schools, community organizations, churches and other agencies in the Grosse Pointe area.

3. The booklet be available at a modest cost to interested persons.

4. Workshops on suicide awareness be available for staff members, including school secretaries.

5. Guidance counselors, school social workers, and administrators be trained to detect suicide potential in students.

6. A curriculum committee for elementary and secondary schools review and recommend ways to incorporate information on suicide. Self-esteem, self-confidence and coping skills should be included in curriculum.

7. Procedures to ease transition of new students should be developed and implemented.

8. Programs on effective parenting, including awareness of suicide, should be promoted through the Department of Community Education. Programs should address the extended family and neighbors.

9. The media should be encouraged to continue to educate the community about the suicide problem and resources available.

10. Teen Helpcards should be made available to all high school students and a modified version to middle school students.

11. A committee appointed by the Superintendent will review and evaluate speakers and/or programs proposed for school presentations. All mental health presentations (Suicide, Substance Abuse, Child Abuse, etc.) should be investigated previous to contract negotiations.

Two subsequent booklets were later printed and distributed to the staff. These two publications, along with the **Sudden Adolescent Death** report were later incorporated into one document for administrative ease. That document is the present form of this presentation.

# EARLY DETECTION AND TREATMENT PROGRAM

## EARLY DETECTION AND TREATMENT

Treatment programs which seem to be successful are included in this publication since many school social workers and psychologists refer to agencies for treatment.

Dr. Susan Blumenthal, Chief, Behavioral Medicine, National Institute of Mental Health in Rockville, MD, states that there are a multitude of factors which impact on suicide. Dr. Blumenthal feels that there is a need for an operational bridge between risk factors and preventive measures.

Psychological autopsies have included the following:

1. Physical and life events
2. Chronic medical illnesses
3. Personality styles
   Example: Aggressive, antisocial, behavior disorder, etc.
4. History of previous attempts
5. Family histories
6. Biology--there is some thought that there may be a biochemical involvement, when grouped with high risk factors, which increases the possibility of suicide.

Aggressivity and impulsivity, when added to substance abuse, dramatically increased the likelihood of suicide.

**Psychological autopsies** revealed that many of the young people who had chosen suicide had the following characteristics:

1. **Offspring of substance abusing parents.**
2. **Offspring of suicides, including grandparents.**
3. **Had no close confidants.**
4. **Abused and neglected children.**
5. **Young people who had recently been under stress, such as a divorce, a move, or a breakup of an important relationship.**

## LEVELS OF DETECTION

1. **Detection awareness**
   Example: Redflagging high risk groups for awareness and educational purposes

2. **Detection of major problem**--this population will need intervention strategies and requires immediate assessment. The first order of business is to establish that the young person is not suffering from a major psychotic disorder which should be treated separately. Symptomatic of major problems would include runaways, unwanted pregnancies, aggressivity, hopelessness and major stress.

3. **Detection of psycotic disorders**

**Psychotic disorders** require psychiatric diagnosis and should not be treated by a lay person. These include

Affective disorder
Conduct disorder
Schizophrenia
Eating disorder
Substance abuse
Alcoholism

There is a great need to give young people direct instruction about coping skills, life management and problem-solving skills, and the awareness of trouble symptoms. There is also a need to educate physicians, clinicians and the judicial to suicide awareness. There is an urgent need to detoxify homes; that is guns, pills or lethal substances should be removed, thrown away or locked up. There seems to be the highest correlation with fatality where there is ready access to a lethal means.

**Active intervention techniques should include**

**Determination of degree of aggressiveness**
**Cognitive development**
**Self-esteem training**
**Stress management**

There is a need for the development of an age-appropriate physical assessment instrument to assist clinicians and counselors when to refer a young person for medical/psychiatric treatment. Early detection and intervention is necessary since it may be difficult for a lay person to discern the difference between the depression and bipolar disorder (the old manic/depressive) and schizophrenia.

Programs which provide social support and use a system approach are more likely to succeed as prevention instruments. Prevention programs sometimes can only succeed with the use of psychotherapy, detoxifying the home, environmental modification and education of the family.

It is noteworthy that adolescents seem to be particularly difficult to treat and just to have patients/clients keep an appointment which was made for them is sometimes impossible.

## SPECIFIC TREATMENT MODALITIES FOR ADOLESCENT SUICIDE ATTEMPTERS

There are some behaviors exhibited by young people which require professional counseling:

1. **Suicide behavior**
2. **Major depressive behavior**
3. **Associated physical illness, including unwanted pregnancies**
4. **Drug and alcohol abuse**
5. **Parental psychiatric illness**
6. **Dysfunctional family--marital conflict**
7. **Parent/child conflict**--a parent may be overprotective causing the child to withdraw

**Who wants treatment?**

**Very few!**

Of the attempters, boys have

more formal psychiatric illnesses
more adverse factors
choose methods of high endangerment

Younger adolescents and girls have

little or no formal psychiatric illnesses
experience acute familial or interpersonal crises
choose low methods of endangerment

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Steele, William Preventing Teenage Suicide. Ann Arbor Publishers, 1984

Suicide Among School-Age Youth. University of the State of New York, The State Education Department, 1984

An extensive collection of booklets and articles on suicide is on file in the Special Education Services Office of The Grosse Pointe Public Schools at 389 St. Clair. Please phone 343 2028 to arrange to review these materials.

A comprehensive selection of information on suicide is available from the Suicide Prevention Center (224-7000).

Additional information is available through the American Association of Suicidology, 2459 S. Ash Street, Denver, Colorado 80222.

VIII

# EPILOGUE

Part of this report was generated through the efforts of a committee of school and community representatives. The committee recommends that a wide network of school, church, agency, and community members be informed about teen suicide prevention.

The committee realizes that suicide is a frightening topic for many people. Yet by bringing suicide out into the open for thoughtful discussion, there can be better understanding of suicide and the feelings which precede it. Counseling young people carefully and with sensitivity can be accomplished at all levels.

The challenge is great for even the most experienced. These efforts may enable students who are at risk to seek professional help, inspire a student to help a friend in trouble, and may save a life.

# Statement on Suicide Addressed to the Grosse Pointe Community

We, members of the Grosse Pointe Ministerial Association, share the grief of families and friends who have experienced the suicide of a loved one. Our hearts go out to them in compassion and our prayers are offered on their behalf.

Every suicide is a tragedy. If any draws more deeply on our profound sorrow, it is the self-destruction of a young person whose life has just begun to unfold and flower.

Suicide is now the second leading cause of death among those between the ages of 15 and 24 in the United States. Only accidents cause more deaths. It is predicted that some 5,000 suicides of people in this age bracket will occur in our country this year.

For every single completed suicide, 50 to 100 young people attempt to kill themselves. That total is staggering. Surely we in this community are well aware that we are not exempt from this national calamity.

A great deal of professional attention has been given to this frightening phenomenon. Studies and reports have multiplied beyond the time and capacity of anyone to absorb.

Churches, public and private schools, social agencies, and counselors and psychiatrists in this area are seeking means to prevent suicide, means to respond to and help in situations that often culminate in the taking of one's life, and means to help the survivors cope psychologically and physically. We are aware of the community-wide study being sponsored by the Grosse Pointe Board of Education and of their efforts to implement relevent programs in the public schools. We applaud and support them. We urge all churches, private schools, and other agencies to provide similar programs for their people.

As members of the Grosse Pointe Ministerial Association, dedicated to a pastoral concern for everyone in our community, we call attention to factors that we feel are decisively involved:

...The need for a strong family life where the intrinsic worth of every person is recognized and each unique individual is held precious.

...The need to communicate acceptance and love to each person in times of success and in times of defeat.

...The need to recognize and cope with signs of depression, such as: noticeable changes in eating and sleeping habits; withdrawal from family, friends and customary activities; persistent boredom; sudden swings in mood; and/or unusual neglect of personal appearance.

...The need to take seriously any threat of self-destruction, however veiled, and to obtain professional help if necessary.

...The need for an awareness that our personal, family and societal goals often contribute to a sense of frustration and even despair on the part of young people.

...The need to let our young people be what they are: children and teen-agers, and to work against the disturbing truth conveyed in such phrases as "the hurried child" or "all dressed up and no place to go."

...The need to recognize that we do not live "by bread alone;" that life is always worth living, primarily when we nourish the spirit and keep in check the age-old illusion that material goals and success bring satisfaction.

...The need to recognize that the fear of failure to achieve such material goals and success undermines a sense of self-worth.

...The need to realize a basic truth common to all living things: life is a gift to be received and nurtured, especially in times of despair. Life offers many hopeful alternatives and it is ours to seek them out.

Finally, we desire to assure the community that we, members of the Grosse Pointe Ministerial Association, share your concern and stand ready to help in whatever way we are able. Please call.

# APPENDIX A

## SOME YOUNG PEOPLE WHO KILL THEMSELVES HAVE LONG HISTORY OF ALCOHOL/DRUGS

The majority of young people who kill themselves have a long history of alcohol and other drug abuse, a San Diego study has shown. Of 133 suicides under 30 years studied, 88 had drug and 72 alcohol disorders. Many had both. Of 150 suicides more than 30 years, 83 had alcohol disorders, but only 39 had other drug problems.

Charles Rich, assistant professor of psychiatry, University of California, San Diego, said alcohol and drug abuse have been recognized factors in suicide, but this is the first study based on hard data. The large number of drug abusers, especially among the young, has not been reported before. His colleague Richard Fowler said, "If we're going to lower the suicide rate in the young, we have to treat alcohol and drug disorders early." They presented their results at the 18th annual meeting of the American Association of Suicidology. Their data were drawn from interviews with survivors, professionals, hospital and coroner records, and from 258 toxicology reports, some of which contained 50 drug screens.

Only two of the young abusers used only alcohol, and most were involved with three or four substances. The young suicides started using drugs at an average age of 15 years, and used them nine years before their deaths. Only 16% of them used drugs or poisons to kill themselves, compared to 24% of the older group. The frequency of specific substance abuse disorders in the young reflected the national US popularity of various drugs: cannabis, 59%; alcohol, 43%; cocaine, 32%; amphetamines, 24%; hallucinogens, 23%; and sedatives/hypnotics, 19%.

Dr. Fowler said many abusers were supported and protected by schools and parents during their teens. "It doesn't hit them until their 20's, but alcohol and drug abuse are progressive disorders, and the situation gets worse with time. The big problem with adolescent abusers is recognizing them early and getting help, even though they are often objecting that they have no problem."

From *The Journal*, published monthly by
Addiction Research Foundation,
Toronto, Canada, June 1, 1985.

# APPENDIX B

## JAPAN UPSET AT COPYCAT SUICIDES AFTER DEATH OF POP STAR

By Peter McGill
London Observer Service

**Tokyo** -The tragic death of a young pop star has triggered a bizarre chain of teen suicides in Japan.

In just one morning, five teenagers jumped from tall buildings, gassed or burned themselves to death. The latest suicides bring the grizzly total to 25 in 13 days.

Most of the teens copied 18-year-old pop idol Yukiko Okada, who leaped to her death from the seventh floor of the building that houses her recording company in Tokyo.

Earlier in April, after a fight with her lover, she attempted suicide by turning on the gas in her apartment. When friends tried to rescue her, she cut her wrists.

Miss Okada finally jumped from the building after being released from the hospital. The lemming-like epidemic of teen suicides began on the following day, April 9.

The youngest suicide was a 9-year-old girl who jumped to her death from the roof of a department store west of Tokyo, after having been scolded by her mother. Her friends told police she had been affected by Miss Okada's death.

In the apartment of one 17-year-old boy who narrowly escaped death after attempting to gas himself, police found the walls plastered with posters of the pop goddess Okada.

Japan has recently been afflicted by a spate of school bullying, which in turn has given rise to a good deal of soul-searching by Japanese on the "sickness" of their youth and the current education system.

Education was the apparent cause of at least one of the recent suicides: 17-year-old Yasuku Aokura, who gassed himself to death by carbon monoxide inside his parents' car in Kobe, left a note saying he was troubled by the prospect of going to university.

The Japan Times newspaper wrote that while it had already been difficult to understand how school bullying had driven teens to suicide in the past, "the Okada suicides seem more phenomenal and challenging to comprehend. There are enough variations in all aspects of these teen-age suicides to say that the initial likeness is nothing more than the inspiration: If Yukiko Okada does not want to live, why should I?"

(Distributed by Scripps Howard News Serv.)

(Editor's Note: According to recent wire service stories, the suicide toll had reached 33 young people in the 17 days following Yukiko Okada's suicide.)

# APPENDIX C

*LETHALITY ASSESSMENT

**These signs, seen even once, represent risk**

| | | |
|---|---|---|
| Giving away of personal possessions | YES | NO |
| Discussion and/or making of suicide plans | YES | NO |
| Discussion and/or gathering of suicide methods | YES | NO |
| Previous suicide attempts or gestures | YES | NO |
| Scratching, marking body, other self-destruction | YES | NO |
| Death themes through spoken, written, and art works | YES | NO |
| Expression of hopelessness, helplessness, and anger at self and the world | YES | NO |
| Use of dark, heavy slashing lines, unconnected bodies in art work and doodling | YES | NO |
| Statements that family and friends would not miss them | YES | NO |
| Recent loss through death | YES | NO |
| Sudden positive behavior change following a period of depression | YES | NO |
| Anniversary of a significant loss | YES | NO |

*The tool on lethality assessment is used by the Suicide Prevention Cntr., Dayton, OH

# APPENDIX D

## GROSSE POINTE COMMUNITY RESOURCES

| | |
|---|---|
| Alanon Family Groups - Cottage Hospital (159 Kercheval, G.P.F., MI. 48236) Tuesday, 8:30 p.m. Saturday, 10:30 a.m. | 527-4610 |
| Alateen - Information and meeting place: Christ Church (61 G.P. Blvd., G.P.F., MI. 48236) Wednesday, 8:30 p.m. | 527-4610 |
| Alcoholics Anonymous - Information | 541-6565 |
| Bereavement Resources - 24-hour Line | 224-1951 |
| Catholic Social Service - Individual and family counseling (19653 Mack, G.P.W., MI 48236) | 881-6645 |
| Chemical Dependency St. John's Hospital Outpatient | 343-3121 |
| Children's Aid Society - Early Attention Program (7700 Second, Detroit, 48202) | 875-0020 |
| Detroit Survivors of Suicide - Emergency Phone Service 24 hours. Suicide Prevention/Crisis Assistance | 224-7000 |

Eastwood Community Clinics - 526-2276
Counseling and Substance
Abuse Program
(Eastland Prof. Bldg.,
17800 E. 8 Mile, Suite 602,
Harper Woods, 48225)

Educational Resource Center - 776-2949
Counseling
(19900 Ten Mile Rd.,
S.C.S. 48081)

Family Life Education Council - 885-3510
Center Point Crisis Center 885-5222
9 a.m. - 9 p.m. Mon-Thurs.
9 a.m. - 5 p.m. Fri.
Medical Clinic 885-5222
6:30-8:00 p.m. Tues.
Legal Center 885-5222
8:00-9:30 p.m. Wed.
Grosse Pointe/Harper Woods
Youth Assistance Program 885-3510
PhoneFriend 885-5744
3:00-6:00 p.m. school days
Alcohol Awareness Program 885-3510
Parenting Workshops 885-3510

Harold Fox Adolescent Alcoholic
Treatment Facility (Pontiac) 858-3177

Grosse Pointe Center for Ind. 823-2011
and Family Therapy
(15200 Kercheval, G.P.P.,
48230)

Grosse Pointe Public School System

| | |
|---|---|
| North Counseling Center | 343-2208 |
| South Counseling Center | 343-2130 |
| Brownell Counseling Ctr. | 343-2120 |
| Parcells Counseling Ctr. | 343-2109 |
| Pierce Counseling Ctr. | 343-2099 |

Grosse Pointe War Memorial - 881-7511
Grief Group, "New Beginnings"
7:00-9:00 p.m. Tuesday
($2.00 per person, per session)

Havenwyck - 373-9200
(1525 University Dr. Auburn Hills, MI, 48057)
Inpatient Child & Adolesc.

Lifeline - 882-LIFE
Christian telephone counseling and referral information on substance abuse and other problems.

Catherine McAuley Health Center 572-3952
(5301 East Huron River Dr. P.O. Box 2506, Ann Arbor, MI 48106)
Teen assessment and treatment.

Macomb County Crisis Center - 573-8700
24-hour line

| | |
|---|---|
| Maplegrove - Adolescent and Adult Substance Abuse (6773 W. Maple Road, W. Bloomfield, MI., 48033) | 661-6100 |
| National Center for Missing and Exploited Children - (1835 K Street, N.W., Suite 700, Washington, D.C. 20006) Provides assistance to parents and law enforcement agencies in locating children and preventing child exploitation. | (202) 634-9821 |
| National Runaway Switchboard Crisis Intervention (Free) | (800) 621-4000 |
| Northeast Guidance Center - Community Mental Health Counseling - Child & Adult | |
| 17000 E. Warren, Detroit | 824-5665 |
| 18134 Mack, G.P. 48224 | 824-5651 |
| Emergency Crisis Number | 224-7000 |
| The Oxford Institute - St. John Hospital Prog. Adult and Adolescent. (825 W. Drahner Road, P.O. Box 429, Oxford, MI 48051) | 962-2658<br>628-0500 |

Operation Home Free - (214)
Provides information on 655-7895
Trailways free transportation home
Detroit Office 259-6681

Planned Parenthood -
(39 E. Adams, Det. 48226) 961-7370
(25921 Gratiot, Roseville, 48066) 779-2500

Pregnancy Aid - 882-1000
(17215 Mack, GP 48224)

Psychiatric Center of Michigan - 88[illegible]-6400
Counseling
(22151 Moross, St. Clair
Professional Bldg.) Det.

Runaway Hotline - Toll Free - (800)
Provides confidential 231-6946
relay of messages from
youths to parents without
revealing location

Rape Counseling Center - 224-4487
Detroit Receiving Hosp.
(4201 St. Antoine, Det.
48201)
24-hour crisis line

St. John Hospital - 343-3121
(see Chemical Dependency)
Outpatient community
facility for chemical
dependency

St. Clair Shores Alternative High School
Continuing Education for out-of-school youths
(23055 Masonic, SCS 48082)
445-4884

Sanctuary -
(1222 S. Washington, Royal Oak, MI)
24-hour line. Provides shelter for runaways.
547-2260

Step-family Association of America
642-8226

St. Joseph West, Mt. Clemens
Adolescent Substance Abuse Facility
286-7700

Tennyson Center -
Substance Abuse
(2465 Collingwood Blvd., Toledo, Ohio 43620)
Adolescents and Adults
(419) 255-5665

The Toledo Hospital
Alcoholism Treatment Ctr.
(2142 N. Cove, Toledo, OH 43606
Adolescents and Adults
(419) 241-3662

Tough Love -
Self-help program for parents troubled by teen-age behavior.
Monday, 7:30 p.m., Grosse Pointe Woods Presby. Church
884-2385

Wayne County Juvenile Court - 577-9100
(1025 E. Forest,
Detroit, 48227)

Wayne County Protective Service - 256-9661
24-hour line
Child Abuse
(801 W. Baltimore,
Detroit, 48202)

The agencies cited may be of assistance. Inclusion in this index is intended for use as a reference source and does not consti tute an endorsement of these agencies by the committee or The Grosse Pointe Public School System.

## Policy of Nondiscrimination

The Grosse Pointe Public School System is committed to a policy of nondiscrimination in relation to race, color, religion, or national origin (Title VI of the Civil Rights Act of 1964); sex (Title IX of the Educational Amendments of 1972); or handicap (Section 504 of the Rehabilitation Act of 1973). (Policy AC) Grievance regulations (Regulation AC-R) are available for those who believe that this policy has been abused.

WAYNE COUNTY INTERMEDIATE SCHOOL DISTRICT
33500 Van Born Road
Wayne, MI 48184

467-1300

**Board of Education**

Charles D. Akey • Boyd W. Arthurs • Armen Barsamian
Mary E. Blackmon • Joan R. Hanpeter

**William Simmons, Superintendent**